

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

62-003726

STATE FILE NUMBER

Registration District No. **318**

Primary Registration District No. **1003**

Registrar's No. **437**

AMENDED

FILED JAN 19 1962

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS
INSTEAD OF

ITEM NO. SHOULD READ

DOCUMENT

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY St. Louis	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN ST. LOUIS, MISSOURI		Length of stay in 1b Days	c. CITY OR TOWN Glendale Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION BARNES HOSPITAL		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) #18 Hillard Rd. Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First KATHRYNE Middle MAY Last FARMER			4. DATE OF DEATH Month JANUARY Day 10 Year 1962
5. SEX Female	6. COLOR OR RACE White	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 10-29-1880
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At home		10b. KIND OF BUSINESS OR INDUSTRY At Home	9. AGE (last birthday) 81
13a. FATHER'S NAME Joseph B. Farmer		13b. MOTHER'S MAIDEN NAME Katherine E. Vogel	14. NAME OF HUSBAND OR WIFE Never Married
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. None	17. INFORMANT Address T. D. Cleage, #18 Hillard Rd. Glendale
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARCINOMA OF LEFT BREAST WITH METASTASES Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____ 170 X			INTERVAL BETWEEN ONSET AND DEATH 6 YEARS
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)			PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)	
20c. TIME OF INJURY Hour _____ a.m. _____ p.m. Month, Day, Year _____			
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION COUNTY _____ STATE _____
21. I attended the deceased from JANUARY 31, 1956 to JAN. 10, 1962 and last saw her/him alive on JANUARY 10, 1962 Death occurred at 6:55 A.M. m on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <i>C. O. Vermillion, M.D.</i> (Degree or title) M.D.		22b. ADDRESS BARNES HOSPITAL	22c. DATE SIGNED 1/10/62
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE Jan. 12, 1962	23c. NAME OF CEMETERY OR CREMATORY Bellefontaine Cemetery	23d. LOCATION (City, town, or county) St. Louis, Missouri (State)
24. FUNERAL DIRECTOR C. R. Lupton & Sons, St. Louis, Mo.		25. DATE RECD. BY LOCAL REG. JAN 11 1962	26. REGISTRAR'S SIGNATURE <i>Roal Smith, M.D.</i>

BY AFFIDAVIT OF

St. Louis
City

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed Arnold W. Schoene

Licensed Embalmer No. 3864
P. O. Address St. Louis, Mo.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).
If embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.